Performance Indicator	Description and units	Baseline		1997	1998	1999	2000	2001	DATA		Responsible Office for reporting data
		Value	Year	Target	Target	Target	Target	Target	Frequency	Source	
SO 4: INCREASED SERVICE UTILIZATION AND CHANGED BEHAVIORS, RELATED TO REPRODUCTIVE/MATERNAL/CHILD HEALTH IN SELECTED DISTRICTS											
.a: Family lanning	Couple years protection[2] distributed in target districts[3] (000s)	109[4]	1996	129	147	164	188	212	Quarterly	HMIS[5]	Contractor/ Grantee
	Couple years protection distributed through social marketing[6] in target districts (000s)	44	1996	71	101	114	133	154	Quarterly	Sales records	Contractor
	Modern contraceptive prevalence[7]	12.5%	1995	14%	--[8]	17%	--	21%	Three times	Two community surveys and DHS	Contractors

1 CYP = 120 condoms, 15 cycles of orals, .29 IUD, 4 injections, .29 Norplant insertions, .13 VSC procedure.

listricts, including 3 CARE districts, where USAID-funded training, supervision are conducted, planned. Not including social marketing sales.

mate based on HMIS data for all facilities in 10 DISH-Project districts. To be replaced by data from 92 facilities (80 DISH, 12 CARE) where data availability and reliability can be more readily assured.

IH Health Management Information System

AID-funded social marketing activity only

0 DISH districts. Baseline is fromm DHS.

no report planned

Performance Indicator	Description and units	Baseline		1997	1998	1999	2000	2001	DATA		Responsible Office for reporting data
		Value	Year	Target	Target	Target	Target	Target	Frequency	Source	
.b: MCH ervices	Annual no. ante-natal visits in target facilities[9] (000s)	443[10]	1996	480	527	580	638	702	Quarterly	HMIS	Contractor/ Grantee
.c: Assisted eliveries	Annual no. of deliveries in target facilities[11] (000s)	59[12]	1996	64	70	77	85	93	Quarterly	HMIS	Contractor/ Grantee
.d: STD eatment	Annual no. of STD visits at target facilities[13] (000s)	72[14]	1996	80	87	96	106	116	Quarterly	HMIS	Contractor
.e: HIV testing nd counselling	Annual no. persons tested and counselled in target districts (000s)	39	1996	50	70	80	90	100	Quarterly	Routine Records	Grantee
.f: HIV Counselling	Annual no. new HIV+ individuals counselled in target districts	3,000	1996	3,250	4,000	4,500	5000	5500	Quarterly	Routine records	Grantee

acilities (80 DISH, 12 CARE) where data availability and reliability can be assured.

IS data for all facilities in 10 DISH, 3 CARE districts. To be replaced with data from 92 facilities (80 DSIH, 12 CARE) where data availability and reliability can be more readily assured.

acilities (80 DISH, 12 CARE)where data availability and reliability can be assured.

IS data for all facilities in 10 DISH, 3 CARE districts. To be replaced with data from 92 facilities (80 DSIH, 12 CARE) where data availability and reliability can be more readily assured.

)ISH districts

IS data for 10 DISH districts. To be replaced with data from 80 DISH facilities where data availability and reliability can be more readily assured.

Performance Indicator	Description and units	Baseline		1997	1998	1999	2000	2001	DATA		Responsible Office for reporting data
		Value	Year	Target	Target	Target	Target	Target	Frequency	Source	
.g: Infant-utrition ehavior	% of infants 4-6 months exclusively breastfed in target facility catchment areas	21%[15]	1995	35%	--	50%	--	60%	Three times	Two community surveys and DHS	Contractors
.h: Sexual ehavior	% of ANC clients 15-19 years old with syphilis (positive RPR) in target facilities	To be esta-blished (TBD)	1997	TBD	TBD	TBD	TBD	TBD	Quarterly	Reviews of ANC registers in facilities	Contractor
	Annual national number of social marketing condoms sold to distributors (millions)	1.3	1992	12	15	17	20	23	Quarterly	Routine records	Contractor
	HIV prevalence among 15-19/20-24 year old pregnant ANC clients: Kampala, Jinja, Mbarara[16]	13.2% 19.5%	1994	7.8% 15.6%	7.4% 14.8%	7.1% 14.1%	6.7% 13.3%	6.5% 12.7%	Annually	Sentinel Surveillance	MOH
R 4.1: Increased availability of reproductive/maternal/child health services											
.1.a: Clinical ervices	% of facilities in DISH districts routinely providing integrated services	66%	1996	71%	76%	81%	86%	90%	Semi-annual	Supervision	Contractor

5 estimate for 10 DISH districts

)H sentinel surveillance sites in districts where USAID activities are implemented.

Performance Indicator	Description and units	Baseline		1997	1998	1999	2000	2001	DATA		Responsible Office for reporting data
		Value	Year	Target	Target	Target	Target	Target	Frequency	Source	
.1.b: ommunity ervices	No. of active community volunteers per catchment area[17] in 10 DISH districts	3/33	1996	4/106	5/114	6/114	6/114	6/114	Semi-annual	Supervision	Grantee
.1.c: HIV esting/ ounselling T/C)	No. of T/C sites in target districts	3	1995	10	20	30	30	30	Quarterly	Routine records	Grantee
R 4.2: Improved quality of reproductive/maternal/child health services											
.2.a: Staff erformance	% of nurses, midwives performing to standard in 10 DISH districts	7%	1995	45%	60%	80%	80%	80%	Annual	Supervision records	Contractor
R 4.3: Enhanced sustainability of reproductive/maternal/child health services											
.3.a: Fees ollected at istrict hospitals	Average % increase in money deposited in bank accounts/month	0	1996	15%	20%	25%	30%	35%	Quarterly	Facility records	Contractor
.3.b: Pre-ervice training apacity	% of trained faculty training to standard	0	1996	14%	34%	60%	60%	60%	Semi-annual	Routine monitoring	Grantee
R 4.4: Improved knowledge and perceptions related to reproductive/maternal/child health											

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served by an NGO participating in USAID-funded community based program

Performance Indicator	Description and units	Baseline		1997	1998	1999	2000	2001	DATA		Responsible Office for reporting data
		Value	Year	Target	Target	Target	Target	Target	Frequency	Source	
4.a: Family lanning	% of non-contracepting women not wanting to become pregnant in 10 DISH districts who fear side effects or lack knowledge of methods, sources	20	1995	17	--	14	--	10	Three times	Two community surveys and DHS	Contractors
.4.b: Infant utrition	% women in target districts who believe it important to breastfeed exclusively for at least 4 months	TBD	1997	TBD	--	TBD	--	TBD	Three times	Two community surveys and DHS	Contractors
.4.c: Maternal ealth	% of women in target districts who can name at least 3 signs of a complicated pregnancy	TBD	1997	TBD	--	TBD	--	TBD	Three times	Two community surveys and DHS	Contractors
.4.d: HIV	% of adults in target districts[18] who know that condom use can prevent HIV infection	22%	1995	32	--	52	--	70%	Three times	Two community surveys and DHS	Contractors
.4.e: STDs	% of adults in target districts who can name at least 2 consequences of an untreated STD	TBD	1997	TBD	--	TBD	--	TBD	Three times	Two community survey and DHS	Contractors

1 districts, excluding Kampala

VI. Activities

The following activities will be financed under this agreement.

Result 1. Increased availability of reproductive/maternal/child health services

USAID will provide assistance to increase the number of public and private-sector clinical staff capable of providing an integrated package of reproductive/maternal and child health services. These staff may include nurses, midwives, physicians, and medical assistants and, resources permitting, nursing assistants. In this context, "integration" means the provision of services based on client need and consistent with provider training during any client/provider contact on any day, regardless of the principal initial reason for the contact. Integrated services will include:

- Family planning;
- Ante-natal care, including screening for pregnancy complications, maternal nutrition counseling, and tetanus vaccination;
- Intra-partum care, including safe deliveries; responses to common obstetric emergencies, including complications of abortions; appropriate referral systems; and care of the neonate;
- Post-natal care, including the promotion of exclusive breastfeeding, optimal complimentary feeding practices, and promotion of full childhood immunization;
- Syndromic STD diagnosis and treatment, based on laboratory validation of management algorithms;
- HIV testing and counseling, with an emphasis pregnant women; and
- Family planning, STD treatment, and counseling for HIV+ individuals.

USAID will support, in the 12 DISH districts, the minor renovation of selected health facilities where trained service providers are posted and will provide basic equipment required for the delivery of those services included in the training.

In coordination with other donors USAID will also supply oral and injectable contraceptives, IUDs and vaginal foaming tablets for the Ministry of Health to provide to health facilities (public and private) in all 15 districts, provided that information on the distribution of said contraceptives to end users is available in a form satisfactory to USAID. USAID will not provide condoms for distribution by the Ministry of Health. USAID will also provide technical assistance to help ensure that public facilities in the 12 DISH districts are reliably supplied with contraceptives and STD antibiotics, via the National Medical Stores.

USAID will support the training of community volunteers to provide education and counseling related to family planning; maternal and infant health and nutrition, including the promotion of breastfeeding and proper weaning practices; and HIV and other STDs and to refer clients to clinics with trained providers for clinical services. They will also sell condoms and oral contraceptives provided through the social marketing program.

To monitor the quantity of services provided, USAID will provide technical assistance and in-country training to district authorities to facilitate the implementation of the Ministry of

Health's Health Management Information System.

USAID will support the social marketing[19], through the private sector, of condoms, oral and injectable contraceptives, and, pending approval by the National Drug Authority, antibiotics for STD treatment, primarily among men. In coordination with other donors, USAID will provide oral and injectable contraceptives for the social marketing program.

Result 2. Improved quality of reproductive/maternal/child health services

USAID will assist in the design and implementation of mechanisms for the routine supervision of clinic and community based service providers. These mechanisms will be based on the observation of trained providers by trained supervisors, as providers actually deliver services. Observations will focus on compliance with formal service-delivery standards based on the content of the training noted above and including client education, counseling and satisfaction. Observations will be recorded on standardized instruments, immediate feedback will be provided tp providers, and records of performance will be maintained for each provider to chart progress and identify persistent problems over time.

Result 3. Enhanced sustainability of reproductive/maternal/child health services

To provide resources to sustain and expand the provision of preventive services, USAID will provide technical assistance to institutionalize, through training and follow up, standardized financial-management systems at health facilities, with an emphasis on hospitals where the potential for revenue generation is highest. (Adequate controls are expected to result in more revenues deposited in institutional bank accounts than is currently the case.) As the use of these systems becomes more common, USAID will work with district and local authorities to plan revenue allocation to improve the quality of maternal and child health services.

USAID will encourage the private sector provision of health services by strengthening the capability of the Uganda Private Midwives Association (UPMA) to provide technical and business-management support to its members, expand membership, and eventually provide refresher technical training. Technical assistance in financial management and cost-accounting and recovery will also be provided to UPMA. Resources permitting, USAID will provide funds and technical assistance to establish endowments to enhance the sustainability of NGOs which have benefitted from previous USAID capacity-building efforts. These organizations could include a UPMA, the Church of Uganda's Family Life Education Project in Busoga Diocese, the AIDS Information Center and/or a local NGO established to operate the social marketing program. Opportunities for assisting in the establishment of pre-paid insurance schemes will be explored.

Per 1 above, USAID will further enhance sustainability by assisting pre-service medical, para-medical and nursing schools to improve curricula and teaching capability in reproductive/maternal/child health.

Result 4. Improved knowledge and perceptions related to reproductive/maternal/child health

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[19] Social marketing activities will be implemented nation-wide, but with special emphasis in the 15 districts noted in IV above.

Behavior is defined as (i) the use of services and (ii) actions not usually construed as utilization of a health service but which effect health. USAID will support service utilization directly by providing accurate information about the services noted above and where to get them. Other behavior change (e.g., correct infant feeding, improved maternal nutrition, condom use, reduction in sexual partners, delayed sexual debut, spousal communication re reproductive health) will be promoted by encouraging people to examine their individual situations; assess their degree of risk, and act accordingly. Behavior change will be promoted through mass-media, local communication activities, and client education and counseling at health facilities.

Implementation

Support for the activities noted under results 1 - 4 above will be provided, at least through September 1999, via currently existing USAID-funded contracts and grants to Pathfinder International; the Futures Group; the African Medical and Research Foundation; CARE; JHPIEGO Corp.; AVSC International; John Snow, Inc.; The AIDS Support Organization; the AIDS Information Center; the U.S. Centers for Disease Control and Prevention; and a personal services contract for an STD advisor.

USAID will fund these organization through two mechanisms. (1) Many but not all of these organizations will receive funds provided through this agreement (bilateral funds). (2) Many of the organizations receiving bilateral funds will also receive funds directly from USAID/Washington (field-support funds). In additions some organizations will receive only field-support funds. Other mechanisms may be identified and used as necessary.

VII. Roles and Responsibilities of the Parties

USAID will, with program funds, provide the technical and administrative personnel required to implement the activities noted above, through the organizations noted above. USAID will also provide, with program funds, locally hired USAID staff required to manage and monitor the Program in compliance with USAID regulations and procedures.

USAID will coordinate activities with the following senior officers of the Ministry of Health: the Commissioner for MCH/FP, the AIDS/STD Control Program Manager, the Commissioner for Health Education, and the Commissioner for Health Planning. In addition to these officers, the principal secretary and Director General of the Ministry of Health, plus a representative of the Ministry of Finance will have signatory authority for all implementation letters and other implementation documents.

In matters of day-to-day activity planning and implementation, the organizations noted above will deal primarily with district-level staff, including representatives of the district medical offices and NGO staff.

The Government of Uganda will fund all costs related to clearing USAID-funded contraceptives (including social-marketing contraceptives) through Ugandan customs and transporting non-social-marketing contraceptives from the customs warehouse(s) to which they are delivered to districts. The Government of Uganda will utilize funds available from the World-Bank-funded STI. project to procure all condoms to be used under the Program,

including properly packaged social-marketing condoms and condoms required by NGOs.

Overall Program monitoring and management will be overseen by an Expanded Strategic Objective Team appointed by the Director of USAID/Uganda, in consultation with the Ministry of Health. This team currently consists of the following individuals:

USAID's Health and Population Officer (Team Leader)
Three USAID Project Management Specialists
USAID's AIDS advisor
USAID's STD advisor
Pathfinder International's Chief of Party
The Ministry of Health's Commissioner for MCH/FP
The Ministry of Health's AIDS/STD Control Program Manager
The Ministry of Health's Commissioner for Health Education
The UNFPA Representative
The Health Program Director of DFID (UK)

In addition, teams composed of representatives of USAID, the Ministry of Health and the implementing organizations noted above ("Results Teams") will manage and coordinate the implementation of the activities noted above and will report periodically to the Strategic Objective Team.

VIII. *Monitoring and Evaluation*

Activities will be evaluated based on (1) routine service statistics to be obtained through the Ministry of Health's Health Management Information System; (2) review by implementing organizations in collaboration with district authorities of health facility records; (3) special community and facility studies implemented by Pathfinder International, and (4) a Demographic and health Survey to be conducted in 2001. Additional monitoring and evaluation activities may be determined by the Strategic Objective Team (above).

ATTACHMENT A

STRATEGIC OBJECTIVE NUMBER 4 (SO 4) FINANCIAL PLAN

	Budget Element	Prior Bilateral Obligations US $	This Bilateral Obligation US $	Total Bilateral to Date US $	Total Estimated USAID Bilateral Contribution US $	Total Estimated Field Support* US $
-	Previous DISH Obligations	23,443,257	0	23,443,257	23,443,257	12,044,000
1.	Service Delivery and IE&C	0	2,474,762	2,474,762	18,099,048	7,722,492
2.	HMIS and Evaluation	0	604,795	604,795	3,510,924	1,338,999
3.	Financing/Sustainability	0	441,936	441,936	2,800,000	1,359,741
4.	Social Marketing	0	388,109	388,109	4,146,771	2,153,262
5.	HIV/STD Activities	0	1,858,918	1,858,918	14,000,000	0
6.	Pre-Service Training	0	0	0	0	3,424,506
7.	Contraceptives	0	0	0	0	3,957,000
8.	USAID Management	0	406,480	406,480	4,000,000	0
	Total	23,443,257	6,175,000	29,618,257	70,000,000	32,000,000

*Field Support Funds, provided by USAID/Washington, not obligated under this agreement, or previous DISH agreement.

SOAG Annex 1
Amplified Description

I. Introduction

This annex describes the activities to be undertaken and the results to be achieved with the funds obligated under this agreement and with funds provided directly to implementing organizations through USAID/Washington for activities in Uganda. Nothing in this annex shall be constructed as amending any of the definitions or terms of the agreement.

II. Background

Uganda's high fertility rate constitutes a fundamental constraint to development across all sectors and is, along with poorly developed maternal and child health services and chronic under-nutrition during childhood, a major contributor to high rates of maternal, infant and child mortality. Overall adult mortality is also very high due primarily to high rates of HIV infection, the transmission of which is facilitated by high rates of other sexually transmitted diseases and high-risk sexual behavior.

The use of modern contraception is low. Only about 7.8% of married women were using modern family planning methods in 1995, although 68% of married women say they either want no more children or want to space their next birth by at least two years. Substantial infant and child mortality is associated with high-risk pregnancies, and two thirds of all births are characterized by one or more risk factors. Maternal mortality accounts for 17% of all deaths among women aged between 15-49 and can be substantially reduced by providing adequate prenatal, delivery and post-partum care; family planning services, and treatment for the sequelae of abortions. Exclusive breast-feeding drops from 77% at under two moths of age to 36% by six moths and thirty-eight percent of Ugandan children are short for their age - a tendency which begins at one month of age and continues throughout childhood.

Over 1.5 million Ugandans are probably infected with HIV - about 15% of the adult population. Awareness of the disease is nearly universal. In addition to its obvious effects on adult mortality, HIV also profoundly affects infant and child mortality. About 27% of infants born to HIV+ mothers in Uganda become HIV+ themselves. Nearly all die by age five. The child of an HIV+ mother is 5.6 times more likely to die before three than the child of an HIV- mother, and it is likely that a substantial portion of infant mortality in Uganda is directly or indirectly related to maternal HIV infection.

STDs are highly prevalent in Uganda. It is likely that HIV and other STDs, especially ulcerative STDs like syphilis and chancroid, interact to increase HIV transmission. In addition, gonorrhea chlamydia are the major cause of pelvic inflammatory disease - a principal cause of gynecological hospitalization in Uganda. Both may be passed on to a child at birth causing potentially blinding ophthalmia neonatorum. Maternal syphilis is probably the major cause of spontaneous abortion, stillbirth and prematurity in Uganda, and children borne to syphilitic mothers are at increased risk of perinatal and infant death and long-term severe illness.

Projected GOU expenditures on health care are very low and disproportionately allocated to hospital based, curative care. While a number of NGOs provide good quality services, they are often highly dependent on donor funding. Some of these organizations represent good

opportunities for endowments for the long-term financing of at least some of their recurrent costs. Aside from perhaps as many as 600 midwives in private practice, there is very limited private-sector provision of modern health care outside urban areas, and few alternatives to public-sector services characterized by low staff salaries, skills and motivation and by the insufficiencies in facilities, equipment, supplies, supervision, training and other support systems found in most health systems in sub-Saharan Africa.

The Program provides assistance related to the following:

- improving skills of clinical-service providers through in- service and pre-service training;
- establishing community outreach mechanisms to provide basic services and education and for referral to clinics with trained staff;
- improving supervisory mechanisms, at facility and community levels, based on observed compliance with service standards;
- increasing the availability of contraceptives and STD drugs,primarily through the private sector;
- facilitating the implementation of the Ministry of Health's health management information system;
- disseminating key information and advice related to reproductive, maternal and child health
- improving financial management of health facilities, especially hospitals
- improving and sustaining the private sector provision of health services

III. Financial Plan

The financial plan for the Program is set forth in the attached table.

Changes may be made to the financial plan by representatives of the Parties without formal amendment of the Agreement, if such changes do not cause USAID's contribution to exceed the amount specified in Section 3.1 of the Agreement.

IV. Results to be Achieved

The objective of the Program is to increase health - service utilization and change behaviors related to reproductive/maternal/child health in up to fifteen[1] districts, vis: Masindi, Luwero, Nakasongola, Kamuli, Jinja, Kampala, Masaka, Mbarara, Sembabule, Rakai, Kasese, Ntungamo, Kabale, Kisoro and Rukungiri. This objective will be accomplished through the attainment of the following results.

1. Increased availability of reproductive/maternal/child health services
2. Improved quality of reproductive/maternal/child health services
3. Enhanced sustainability of reproductive/maternal/child health services
4. Improved knowledge and perceptions related to reproductive/maternal/child health

V. Indicators

Progress in attaining the program (strategic) objectives and the four results noted above will be measured per the attached Performance Data Matrix.

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[1] Nakasongola and Sembabule (newly created from Luwero and Masaka) and Kabale, Kisoro and Rukungiri (districts served largely by CARE), will receive more limited USAID support than the remaining 10 districts supported to date under the Delivery of Improved Services for Health (DISH) Project.